assessed with an age appropriate Ages and Stages Questionnaire completed by their mother.

Results: Recruitment began in July 2013 and by the end of 2015, 210 women completed their six month assessments. Of the 210 women assessed, 161 were normotensive in pregnancy and 49 hypertensive (40 PE, 9 GH). As expected, women with hypertension gave birth earlier and had smaller babies.

Conclusions

References

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Clinical science

140 Nurses working process of evaluation and doctors in the prevention of factors hypertension risk pregnancy

Gestational hypertension
Janaína da Silva Feitoza Palácio, Roberta Grangeiro de Oliveira, Zélia Maria de Sousa Araujo Santos, Geraldo Bezerra Silva Jr., Paula Dayanna Sousa dos Santos, Amábili Couto Teixeira de Aguiar, Geraldo Flamarion da Ponte Liberato Filho, Rithianne Frota Carneiro, Laurineide de Fátima Diniz Cavalcante, Meirylane Gondim Leite, Sâmila Guedes Pinheiro, Kátia Alves Ferreira Rodrigues, Nayara de Castro Costa Jereissati, Teyla Bastos Leite Andrade, Mirella Coelho Paiva (Universidade de Fortaleza, Fortaleza, CE, Brazil)

The Prenatal Care (APN) appears as an instrument to extend assistance beyond the purely curative question , enabling these pregnant women for self-care and therefore to maintain their health. It is important to point out that prenatal care should not be restricted to the clinical and obstetric actions, but include health education actions in the routine of comprehensive care, as well as anthropological, social, economic and cultural rights, which should be known by professionals who assist pregnant woman, seeking to understand them in the context in which they live and encouraging the pregnant woman globally participate in decisions involving their health. This study aimed to evaluate the prenatal care with a focus on structure and process from the perspective of the Family Health Team (EqSF) and coordinators of primary care units in Health (UAP). Research evaluative type, held on 20 UAP with 14 coordinators of units, 36 nurses and 35 doctors. The UAP presented with an unsatisfactory structure for prenatal care quality. The physical plant, material resources, the system of care and the queues have exposed the need for a more careful look, by the management of the units. According to the criteria established in this study, the UAP are presented with an unsatisfactory structure for prenatal care quality. The physical plant, material resources, the system of care and the queues expose the need for a more careful look, by the management of the units, this first Donabedian assumption. Based on the analysis of the results EqSF lacks a reflection on their work process in promoting women's health, so that the service can offer a quality APN. As for the process, it was observed that nurses (as) and the doctors had similar attitudes when the approach and the behavior inherent in the physical examination. But nurses (the) were (as) that stood out as health educators.

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Clinical science

141 Eclampsia as the first presentation of peripartum cardiomyopathy

Imitators of preeclampsia
Aleksandra Ilic [a], Djordje Ilic [b], Snezana Stojsic [a], Maja Stefanovic [a], Snezana Tadic [a], Anastazija Stojsic-Milosavljevic [a], Dragana Grkovic [a], Katica Pavlovic [a], Jadranka Dejanovic [a] ([a] Institute of Cardiovascular Diseases of Vojvodina, Novi Sad, Serbia, [b] Clinical Center of Vojvodina, Department of Obstetrics and Gynecology, Novi Sad, Serbia)

Introduction: In some cases eclampsia (which is the main cause of mortality during pregnancy) may be associated with peripartum cardiomyopathy (the main cause of serious complications during pregnancy and postpartum period).

Case report: Female patient 36 years old, in the 30th week of gestational (the first pregnancy), previously completely healthy, was admitted to hospital due to syncope, convulsion and hypertension (160/100 mmHg). The caesarean delivery was performed immidiately. ECG and echocardiography were without pathological findings, but because of elevated troponin I (0,19) and NT pro BNP (1500), CT coronary angiography was performed. The finding on coronary arteries was completely normal. After improvement in clinical symptoms, values of blood pressure and laboratory findings, patient was discharged. Three months later (in the meantime she didn't come on the routine clinical folow-up) she was again admitted to hospital due to dyspnoea, peripheral edema and palpitations. Symptoms had begun ten days before that. Physical examination indicated systolic murmur at the apex, signs of left and right heart failure. Laboratory analysis showed leukocytosis, anemia, increased liver ensymes AST (62), LDH (531), uric acid (548), CRP (7,5) and significant increase of NT pro BNP (20975). Electrocardiogram pointed to tachycardia and T-wave inversion in standard and precordial leads.

Chest X-ray demonstrated enlarged heart shadow without pathological changes in the lungs. The patient underwent an echocardiography exam which showed dilated left ventricle, global hypokinetic, with low ejection fraction (25%) and with large thrombus in the apex, with very high embolic potential. It also demonstrated moderate mitral regurgitation.

The patient was treated according to guidelines on acute and chronic heart failure with ACE inhibitors, beta blockers, diuretics, mineralocorticoid receptor antagonists, also with anticoagulant therapy and supstitution therapy of folic acid and iron, with addition of bromocriptine. Two months later she was symptomless, while echocardiography showed improvement in ejection fraction (45–50%), reduction of mitral regurgitation and completely resolution of the left ventricle thrombus.

Finally, about twelve months later, coming to a complete clinical, laboratory, ECG and echocardiography restitution.

Conclusion: In case of presentation of eclampsia it is necessary to follow up the patient frequently not to miss the beginning of sytolic disfunction due to peripartum cardiomyopathy, which may be coused by eclampsia. It is also important to be aware that some cases need more time (not only six months) for complete restitution.

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